Important Notice Regarding Fraud

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ***For residents of California***: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Hampshire:*** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Important Notice Regarding Fraud

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM FORM

IMPORTANT INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

To expedite claim processing, the attached claim forms need to be fully completed and the following instructions must be adhered to. Each claim will be evaluated based on the terms and conditions of the insurance policy. The Insurance Company reserves the right to request additional information and/or documents to help us make this evaluation. The acceptance of these forms by the Insurance Company is not an admission of coverage under an insurance policy.

Part I – Employer's Statement

Form must be completed in its entirety and certified by an official representative of the employer or the plan.

For employee paid coverage, the employer must attach a copy of the enrollment form and any history to show timely enrollment and premium payment.

Please provide proof of salary (attach W2 or commissions, if applicable)

Please provide the beneficiary designation forms on file with the policyholder, if any. If none on file, the official representative shall certify to that fact on the claim form.

Part II – Claimant's Statement

To be completed by claimant or beneficiary in its entirety.

Please furnish any newspaper accounts or other pertinent information regarding the claim.

Part III – Attending Physician's Statement (required for accidental dismemberment claims)

Attending physician must complete this form. Any expense for completion of the form will be paid for by the claimant.

Part IV – Attending Physician's Dismemberment Form

If your claim involves a dismemberment, please have your physician complete pages 5-6 to identify the location of your dismemberment(s), sign and date.

Miscellaneous – All Claims

Required documents other than claim form

- Certified true copy of death certificate (Accidental Death Claim)
- Police Report (if applicable)
- Autopsy/Post Mortem & Toxicology report (if applicable)
- All relevant medical reports

If the claim proceeds are payable to an estate, Part II must be completed by the executor or administrator of the estate. A copy of the court document appointing the executor or administrator must be attached to this form.

If any designated beneficiary is a minor, Part II must be completed by the custodian or guardian. A copy of the court document appointing the guardian or a similar document must be attached to this form.

For a foreign death, the official death certificate and the Report of the Death of an American Citizen Abroad form must be attached to the claim form.

Mail Claim Forms to:

Provident Claims Services, Inc.
PO Box 38295
Pittsburgh, PA 15238-8295
Toll-Free: 800.478.1752
Fax: 412.963.0148
claims@providentclaims.com
www.providentclaims.com

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ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

PART I: Employer's Statement

Accidental Death & Dismemberment

Claim Form for EMPLOYEE or DEPENDENT

Group Policyholder/Employer Name:			
Group Policyholder/Employer Address:			
Name of Insured Employee/Participant:		Date of Birth:	Social Security Number:
Name of Deceased or Injured (if different from above):		Date of Birth:	Social Security Number:
Relationship to Employee:	Phone:	Employee Class #:	Location:
Address:			
Did the Employee Select Family Coverage? (if applicable): ◯Yes ◯No	Employee's Marital Status: ◯Married ◯Single ◯Divorced ◯Other_____		
Please list the dates of birth and names of the Employee's Dependent Children (if any):			
Date of Injury:	Employee Status on Date of Injury ◯Active ◯Retired ◯FMLA ◯Other (explain):		
Employee was: ◯Full time ◯Part time	◯Salaried ◯Hourly	◯Exempt ◯Non-exempt	◯Commissioned ◯Other (Explain)
Effective Date of Coverage for Employee:	Employee Salary on Date of Death:		
Employee Occupation/Title/Position:	Date Employment Commenced:		

Policy Number (please check all that apply and include policy number):

◯ Employer Paid AD&D: _____

◯ Employee Paid AD&D: _____

Amount of Coverage:

◯ Employer Paid AD&D: _____

◯ Employee Paid AD&D: _____

Beneficiary Information

Is Beneficiary Designation Card on file? ◯Yes ◯No If "Yes", a copy must be submitted to us.

Is there an Assignment on file? ◯Yes ◯No If "Yes", a copy must be submitted to us.

Employer Certification

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Authorized person) _____ Date_____

NAME _____ TITLE _____ PHONE NO. _____

PROVIDENT | CLAIMS SERVICES

ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

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PART II: Claimant's Statement

Accidental Death & Dismemberment Only

Claim Form for EMPLOYEE or DEPENDENT

INSTRUCTIONS: Complete this form if you are applying for death or dismemberment benefits due to an Accident.
If a question does not apply, please mark "N/A".

GROUP POLICYHOLDER/EMPLOYER NAME:

Name of Insured Employee/Participant	**Social Security Number**
Name of Deceased or Injured (if different from above)	Has a Workers Compensation claim been filed? ◯ Yes ◯ No If "Yes", what is the status of the claim?
Relationship to Employee: ◯ Spouse/Domestic Partner ◯ Child Date of Birth:	

On what date did the accident happen? _____ Where did the accident happen? City _____ State _____
Please describe all injuries received.

Did accident result in death? ◯ Yes ◯ No If "Yes", on what date? _____

Describe in detail how the accident occurred.

Name and address of law enforcement agency involved (Please submit copy of Police Accident Report).

List name/address/phone # of all physicians consulted for this injury/death.

List name/address/phone # of all hospitals consulted.

Did the deceased/injured have any chronic disease or physical defect or deformity? ◯ Yes ◯ No If "Yes", describe in detail:

Was autopsy performed? ◯ Yes ◯ No If "Yes", provide name/address/telephone number of coroner, if known	Was an inquest held? ◯ Yes ◯ No If "Yes", verdict?

Name of Beneficiary	Address	Telephone Number	Social Security Number:

Your date of birth _____ In what capacity are you making claim? _____
(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)

Your address _____ and

Telephone number _____ (if different from beneficiary).

Your relationship to deceased or injured _____ Your Social Security Number _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the deceased or insured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV and alcohol/drug records to release all such records in their entirety to AXIS Insurance Company, and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time be sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier. I understand that by signing this form I may be authorizing the use and disclosure of my confidential protected health information to AXIS Insurance Company.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

PROVIDENT | CLAIMS SERVICES

ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

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PART III: Attending Physician's Statement

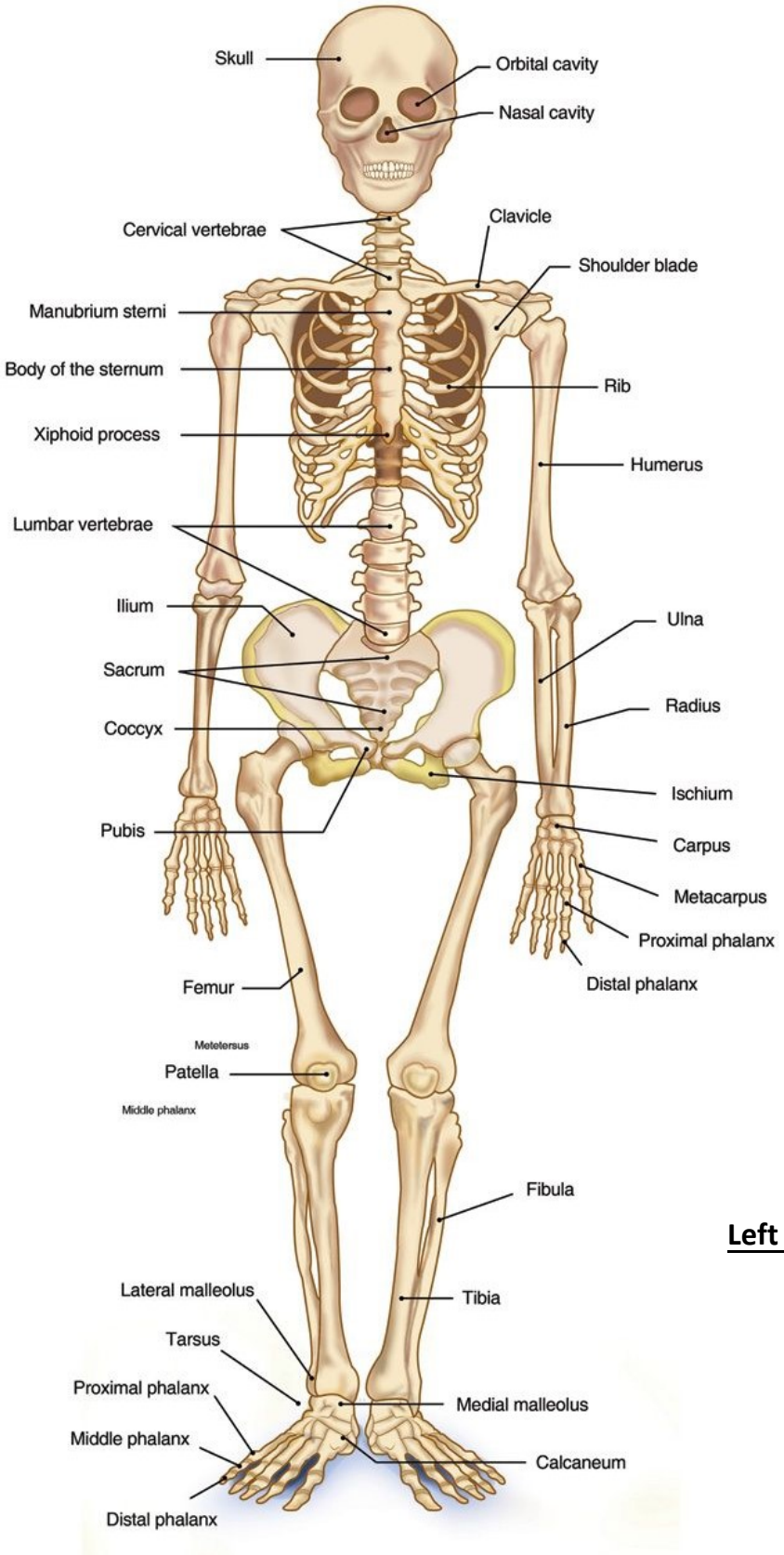
Required for all accidental dismemberment claims.

Attending physician must complete this form. Any expense for completion of the form will be paid by claimant.				
Name of Patient:	Date of Birth:	Address (Street, City, State, Zip Code):		
When did accident happen? (Month, Day, Year)	When did patient first consult you for this condition? (Month, Day, Year)			
Nature of injury: Please explain in complete detail, including all diagnoses, any dismemberment or loss of use; the cause or incident causing the injury, and all affected body parts.				
If injury resulted in severance of a body part, please indicate the precise location of the severance. If amputation was required provide each individual CPT code.:				
Did injury result in the total and irrecoverable loss of hearing in both ears? ◯ Yes ◯ No Date of loss:				
Did the injury result in: ◯ Paralysis	◯ Quadriplegia	◯ Paraplegia	◯ Hemiplegia	
In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above?				
If an operation is contemplated, give approximate date and nature of the operation:				
In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? ◯ Yes ◯ No				
If injury resulted in loss of sight, was the loss total and irrecoverable? ◯ Yes ◯ No Which eye was injured? ☐ Right ☐ Left Was the eye removed? ◯ Yes ◯ No On what date did the total and irrecoverable loss occur? If the loss of sight is partial, but irrecoverable, please state amount of vision in each eye with Snellen notations, or Jaeger scale, if pertinent.				
Uncorrected O.D.	O.S.	Corrected O.D.	O.S.	Date of Examination
Do you believe vision can be restored in whole or in part by treatment or operation? ◯ Yes ◯ No				
Was patient confined to a hospital? ◯ Yes ◯ No If "Yes", give name and address of hospital and dates of confinement:				

Treatment				
Date of first visit	Dates of Subsequent Visits			
Is patient still under your care for this condition? ◯ Yes ◯ No				
If discharged, give date of discharge:				
Signature of Attending Physician	Physician's Name (Please Print)	Degree	Telephone	Date
Street Address:	City or Town		State or Province	Zip Code

Part IV: Attending Physicians Dismemberment Form

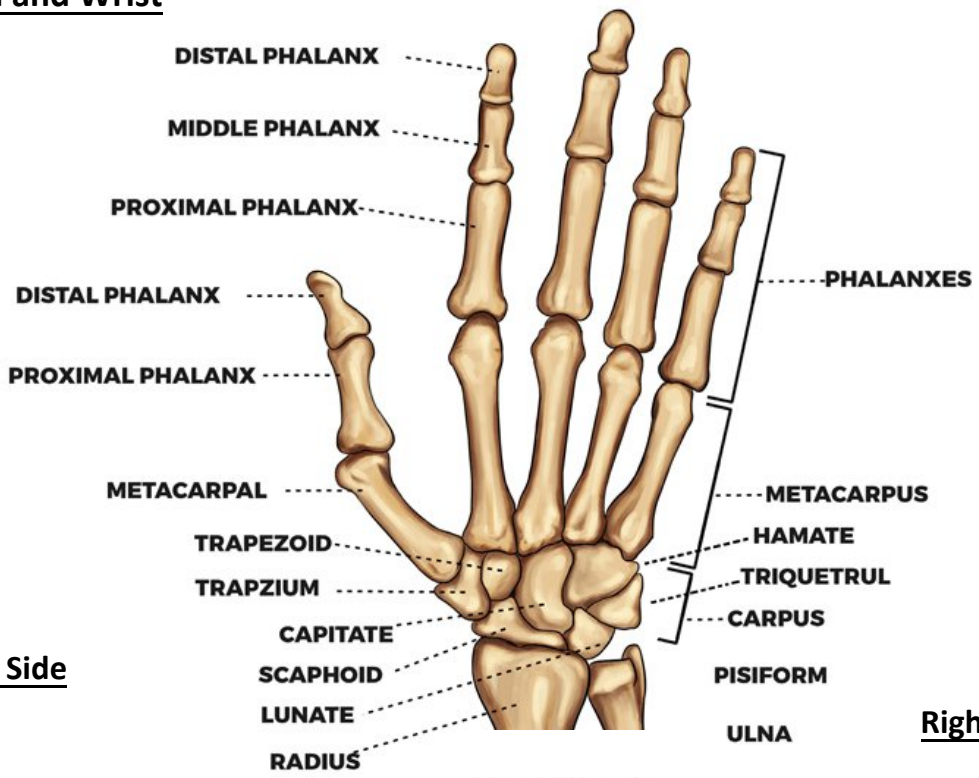
1. **Identify the severance/amputation(s) below, by marking the exact location , indicate R or L.**
2. **Sign the bottom of page 6, verifying the information.**



Right Side

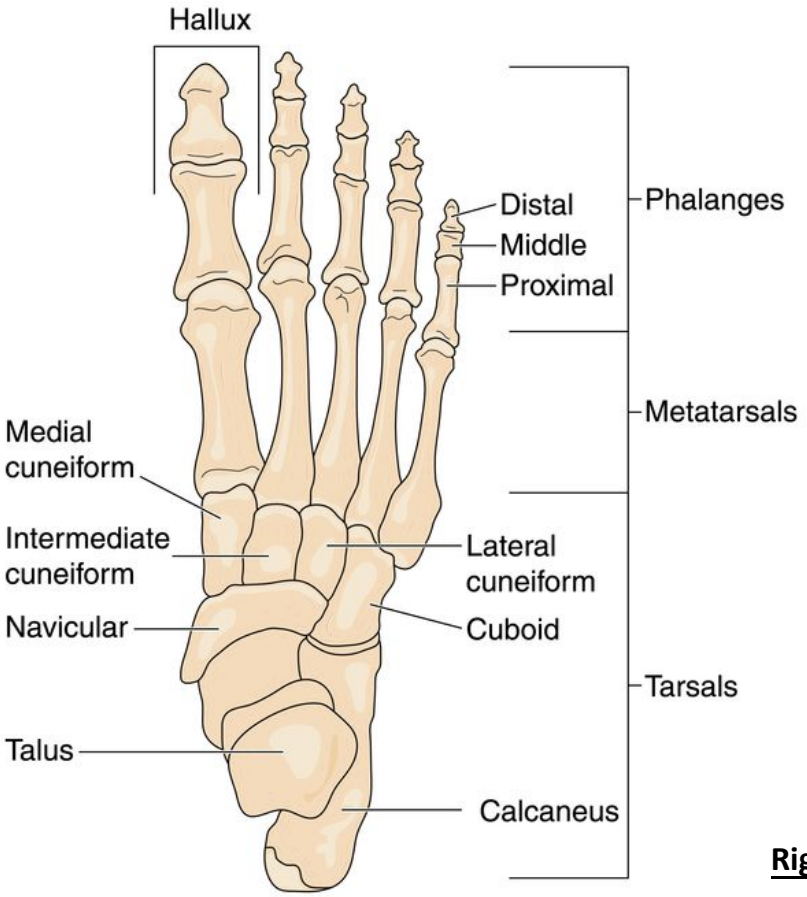
Left Side

Diagram of Hand and Wrist



Left Side **Right Side**

Diagram of Foot



Left Side **Right Side**

Physician's Name/Title: _____ Date Completed:_____

Physician's Signature: _____Date Signed:_____

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ACH Direct Deposit Authorization Form

Authorization Agreement (ACH Direct Deposit Only). By signing below, I (the "Receiver") authorize Provident Claims Services, Inc. (PCS) (the "Originator") to initiate Automated Clearing House (ACH) credit entries (direct deposits) to the deposit account identified below (the "Account"). This authorization is limited to the direct deposit of claim payment proceeds and any permissible correcting entries related to those deposits.

☐ **ACH CREDITS ONLY ACKNOWLEDGMENT. By checking this box, I acknowledge and agree that this authorization permits PCS to initiate ACH credit entries (direct deposits) ONLY. No ACH debit entries will be initiated to my account under this authorization.**

This form is to be used for PCS direct deposit of funds only.

Request Type:	◯ New Authorization ◯ Change Existing ◯ Discontinue Service
Receiver SS# or FEIN #:	Receiver Name:
Start Date:	Receiver Phone Number:
On behalf of (claimant, minor, etc.)	Receiver Email Address:

No Liability for Bank Delays/Incorrect Information. I understand the Originator is not responsible for delays or losses caused by incorrect or incomplete information I provide, actions or errors by my financial institution, or events outside the Originator's reasonable control.

Compliance and Dispute Cooperation. Entries initiated under this authorization will comply with the Nacha Operating Rules and applicable U.S. law. I certify that I am an authorized signer or owner of the Account and authorize my financial institution to provide information needed to resolve any entry, return, or notice of change related to this authorization.

Revocation/Changes. This authorization will remain in effect until the Originator receives my written notice to change or revoke it. Any change or revocation request must be received at least five (5) banking days before the next scheduled deposit date to allow a reasonable opportunity to act.

Notice of Issues. I will promptly review my Account activity and notify PCS if a direct deposit has not been received or if an amount is incorrect. To the extent permitted by law and the Nacha Rules, claims relating to an unauthorized or erroneous entry are subject to applicable reporting timeframes.

Correction, Reversal, and Adjustments for Errors. If an entry is made in error (including an incorrect amount, duplicate entry, wrong account, or wrong effective date), I authorize the Originator to initiate a correcting entry or reversal as permitted by the Nacha Operating Rules and applicable law. The Originator will make reasonable efforts to notify me of any reversal and the reason for it as required by the Nacha Rules.

Account Verification and Receipt of Entries. I authorize the Originator and its financial institution to verify my Account information, including by initiating one or more prenotification (zero-dollar)

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entries or other commercially reasonable verification methods, and to deposit funds to the Account in accordance with this authorization.

ACH Direct Deposit Authorization Instructions:

1. Please complete and submit this form to the Provident Claims Services, Inc.: PO Box 38295, Pittsburgh, PA 15238 | Email: claims@providentclaims.com | Phone: (412) 909-4991 | Fax: (412) 963-0148

2. Please attach a voided check for the account into which funds will be deposited or obtain the account and routing numbers directly from your financial institution.

3. Select New Authorization, Change Existing, or Discontinue Service, as applicable.

Primary Account Information

Name of Financial Institution:		
	Account Type: ◯ Checking ◯ Savings	Account Category: ◯ Personal ◯ Commercial
Routing Number:		
Account Number:		

Privacy and Data Use Notice. PCS will use the banking and personal information provided on this form solely for the purpose of initiating and administering ACH direct deposit transactions and for related operational, legal, and compliance purposes. Such information will be maintained and safeguarded in accordance with applicable federal and state privacy and data security laws, including the Gramm-Leach-Bliley Act (GLBA), and will not be disclosed to third parties except as necessary to process ACH transactions, comply with law, or as otherwise permitted by applicable regulations.

Signature

Authorized Signature (Primary):	Date:
Authorized Signature (Joint):	Date:

Please attach a voided check and return this completed form in its entirety to the PCS.